Abstract evidence map

Abstract statement	Supporting exhibits	Status
The ASC operated below potential despite efficient operations	Figures 2a, 2b; Tables 1, 2	Supported
Overbooking and extended hours did not produce the expected improvement	Figure 3	Partially supported
Patients reported as waiting were not always ready to be scheduled	Figure 4; Table 3	Indirect evidence only
13,185 procedures; Main OR 83.5% committed vs. ASC 68.6% committed	Figure 1; Table 1	Partially supported
About 2,540 funded, uncommitted ASC hours	Figures 2a, 2b; Table 2	Supported
Patients were in queues while block hours remained unbooked	Figure 5; Table 4	Supported
A decision framework that other programs can adapt	Figure 8	Supported
Main OR and ASC managed as complementary enterprise assets	Figures 9, 10, 11; Table 5	Supported
Modeled capacity and financial scenarios are not realized outcomes	Figure 10	Partially supported

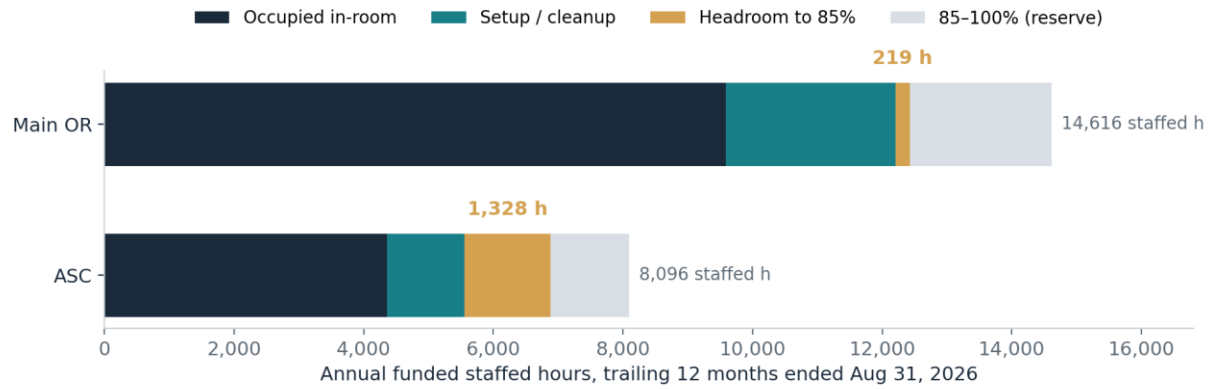
White paper figures compared with the volume extract

Table 1. Volume, utilization and room-day measures, 12 months ended August 31, 2026

Measure	White paper [D1]	Volume extract	Status
Enterprise cases	13,185	13,185	Matches
Main OR cases	8,126	8,126	Matches
ASC cases	5,059	5,059	Matches
Add-on cases (Main OR / ASC)	Not reported	1,689 / 186	Not reported
Weekend or holiday cases (Main OR / ASC)	Not reported	406 / 0	Not reported
ASC staffed room-days with no cases	85	85	Matches
Days with all four ASC rooms active	175 of 253	175 of 253	Matches
ASC in-room utilization	53.9% (in to out of room)	49% (in room to procedure complete)	Different measure
Main OR in-room utilization	65.6% (in to out of room)	59.2% (in room to procedure complete)	Different measure
ASC committed utilization	68.6%	Setup and cleanup not recorded	Not in extract
Main OR committed utilization	83.5%	Setup and cleanup not recorded	Not in extract
ASC median turnover	14.8 min (out to next in)	19 min (procedure complete to next in)	Different measure
Main OR median turnover	26.0 min (out to next in)	29 min (procedure complete to next in)	Different measure
GI cases, Oct 2025–Sep 2026 (Main OR / ASC)	2,006 (1,473 / 533)	2,006 (1,473 / 533)	Matches
GI add-on cases	156	156	Matches
GI weekend cases	26	27	Matches

Exhibits supporting the abstract

Figure 1. Enterprise headroom to an 85% planning line, in hours

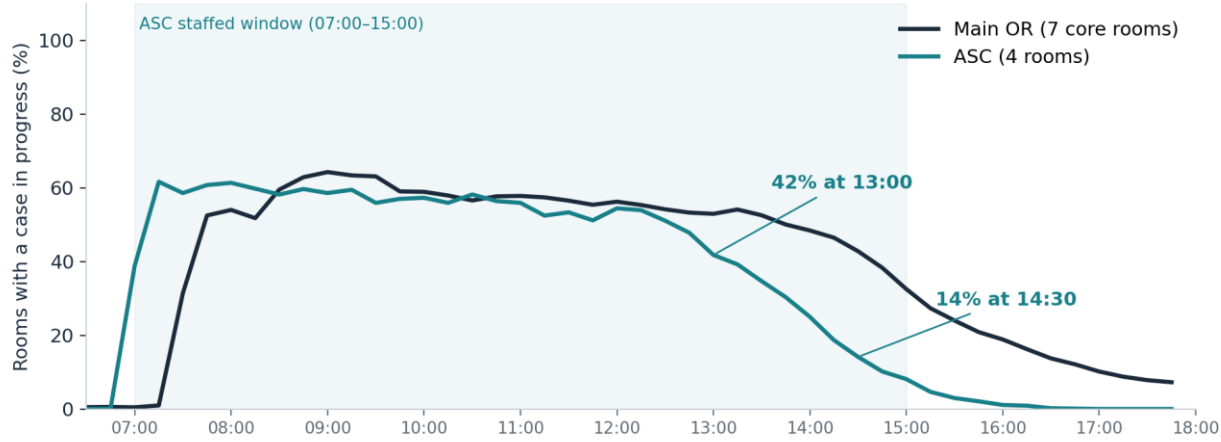


Abstract statement supported: The Main OR was 83.5% committed while the ASC was 68.6% committed.

Finding: Measured in hours to an 85% planning line, the Main OR has about 219 hours of usable headroom and the ASC about 1,328.

Basis and source: White paper figures [D1], trailing 12 months ended August 31, 2026. Case counts confirmed by the volume extract (Table 1).

Figure 2a. Share of rooms with a case in progress, by time of day



Abstract statement supported: The ASC operated below its potential despite efficient operations.

Finding: ASC rooms run at the same level as Main OR rooms through late morning. ASC activity then falls to 42% of rooms by 13:00 and 14% by 14:30, well before the end of the staffed day.

Basis and source: Volume extract, weekdays, September 2025–August 2026.

Figure 2b. How ASC staffed time was used



Abstract statement supported: The ASC had about 2,540 funded, uncommitted hours.

Finding: 2,272 staffed hours (28%) fell after the last case of the day or in rooms that ran no cases. ASC Room 4 accounts for 44 of the 85 empty room-days.

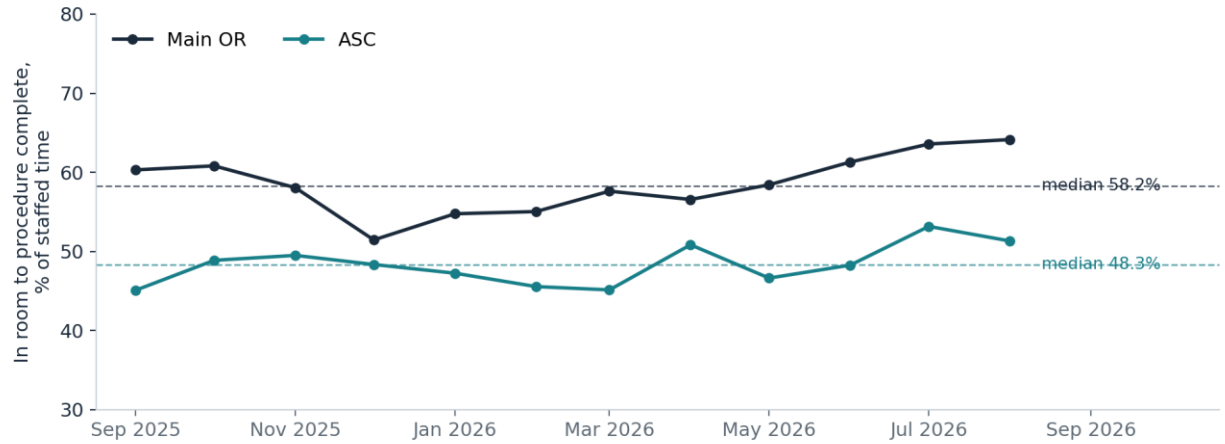
Basis and source: Volume extract, weekdays, September 2025–August 2026, within the 07:00–15:00 staffed window.

Table 2. ASC staffed time by use, September 2025–August 2026

Component	Hours	Share of staffed time
In room to procedure complete	3,915	48%
Between cases (exit, cleanup, setup, turnover)	1,563	19%
Before the first case of the day	347	4%
After the last case of the day	1,592	20%
Staffed room-days with no cases (85)	680	8%
Total funded staffed time	8,096	100%

Empty room-days by room: Room 1, 9; Room 2, 19; Room 3, 13; Room 4, 44.

Figure 3. Monthly room utilization by site, September 2025 to August 2026

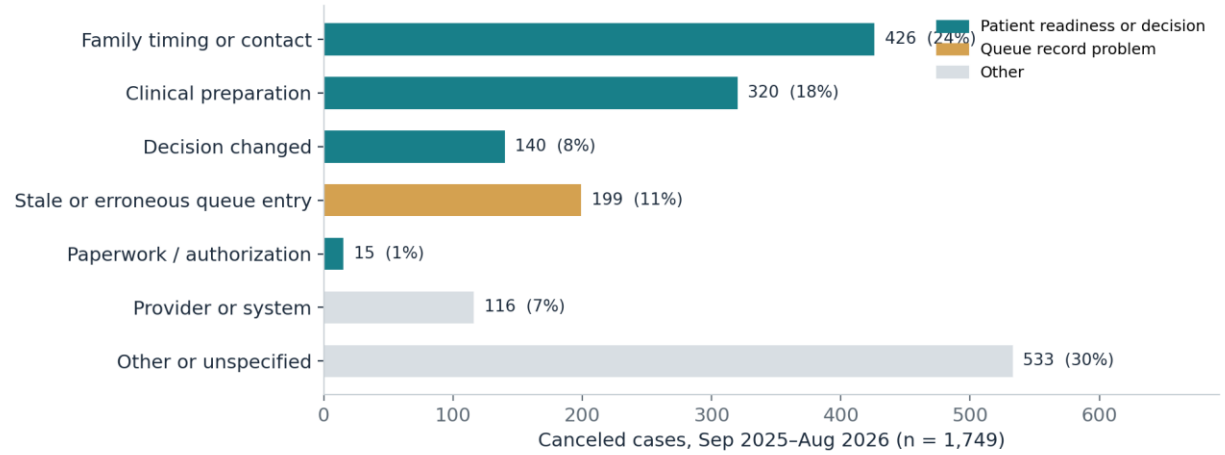


Abstract statement supported: Overbooking and extended hours did not produce the expected improvement.

Finding: ASC utilization stayed between 45.1% and 53.2% every month (median 48.3%), with no sustained step change. The Main OR ran consistently higher (median 58.2%).

Basis and source: Volume extract. In room to procedure complete, as a share of weekday staffed time.

Figure 4. Reasons scheduled cases were canceled, September 2025 to August 2026



Abstract statement supported: Patients reported as waiting were not always ready to be scheduled.

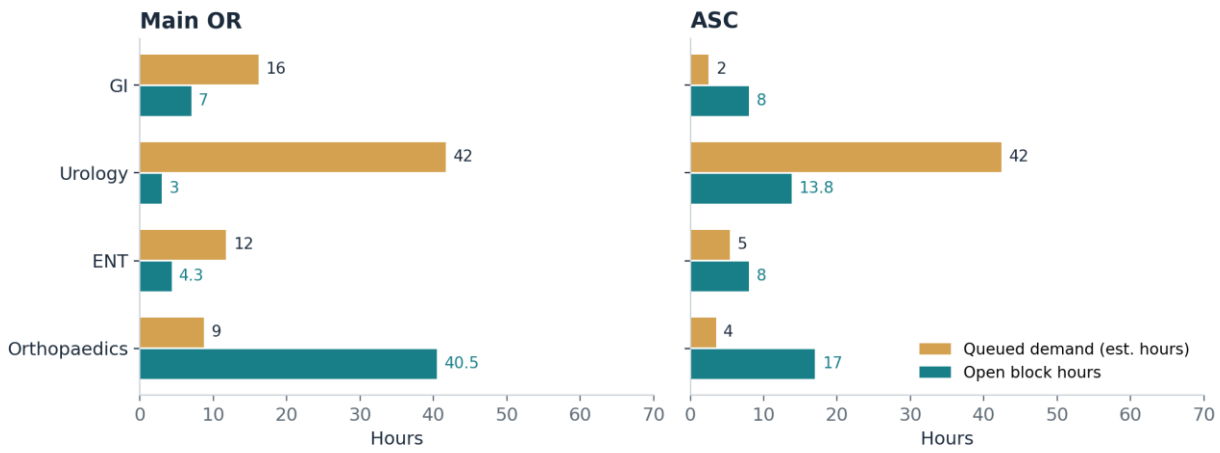
Finding: Of 1,749 canceled cases, 901 (52%, or 74% of those with a specific reason) were canceled for reasons tied to patient readiness, a changed decision, family timing or contact. A further 199 were stale or erroneous entries, including 99 auto-canceled after more than a year untouched.

Basis and source: Volume extract, canceled cases dated September 2025–August 2026. Reasons grouped to the readiness categories used in the proposed readiness audit.

Table 3. Cancellation reasons by group

Group	Recorded cancellation reasons	Cases
Decision changed	Patient Condition Improved (113); Completed Previously Non-Emergent (8); Patient's Family Refused (11); Patient Refused (Comment Required) (8)	140
Clinical preparation	Patient Illness (209); Patient Not NPO (11); Medical Clearance (Comment Required) (10); Anesthesia Pre-Op Clearance (Comment Required) (3); Canceled in Pre-op (87)	320
Paperwork / authorization	Financial Clearance (12); Insurance/Authorization Issue (3)	15
Family timing or contact	Parent/Guardian Request (368); Unable to Contact (44); Patient No Show Day Of Surgery (14)	426
Stale or erroneous queue entry	Auto-Cancelled, Case Untouched for >365 days (99); Scheduling Error (74); Change Of Location (6); Offsite Surgery (8); Shuffling Order of Cases (12)	199
Provider or system	Surgeon Misc Cancel (Comment Required) (105); Surgeon Faculty Not Available (3); Weather (4); COVID-19 (4)	116
Other or unspecified	Other, comment required (501); blank (17); remaining low-volume reasons	533
Total		1,749

Figure 5. Queued demand and open block hours in the same units



Abstract statement supported: Patients were in queues at the same time that block hours remained unbooked.

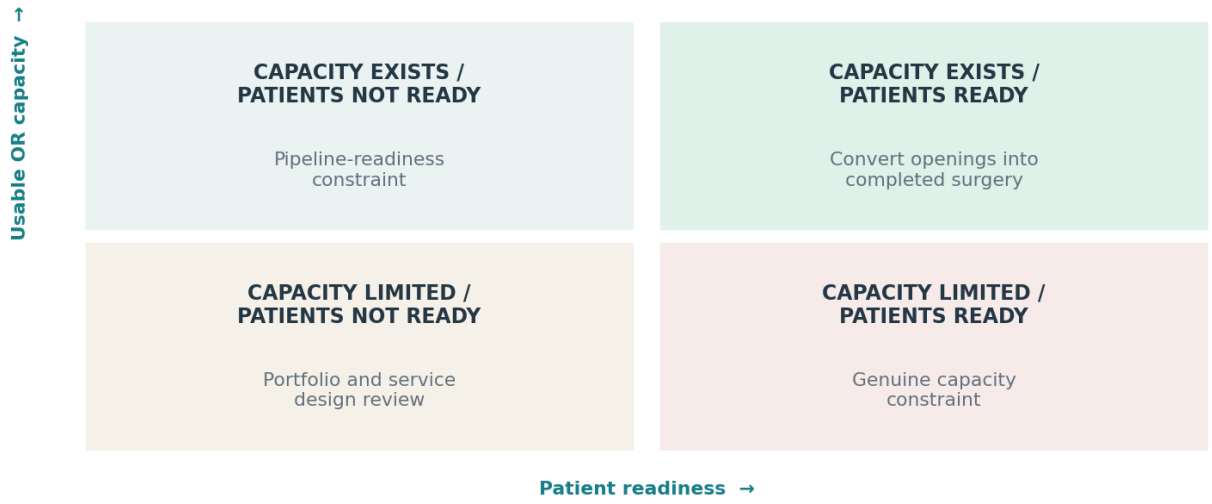
Finding: GI queued demand sits at the Main OR while open GI time sits at the ASC. Orthopaedics has more open hours than queued demand at both sites. Urology queued demand exceeds open time at both sites.

Basis and source: Queue counts and open hours: white paper scheduling snapshot, four-week look-ahead, week ending August 7, 2026 [D1]. Hours per case: median in room to procedure complete by specialty and site, Volume extract.

Table 4. Queue converted to hours, by specialty and site

Specialty	Main OR queue [D1]	Main OR median h per case	Main OR est. demand h	Main OR open h [D1]	ASC queue [D1]	ASC median h per case	ASC est. demand h	ASC open h [D1]
GI	51	0.32	16	7	10	0.25	2	8
Urology	41	1.02	42	3	48	0.88	42	13.8
ENT	22	0.53	12	4.3	27	0.2	5	8
Orthopaedics	7	1.25	9	40.5	6	0.58	4	17

Figure 8. Readiness-by-capacity diagnostic

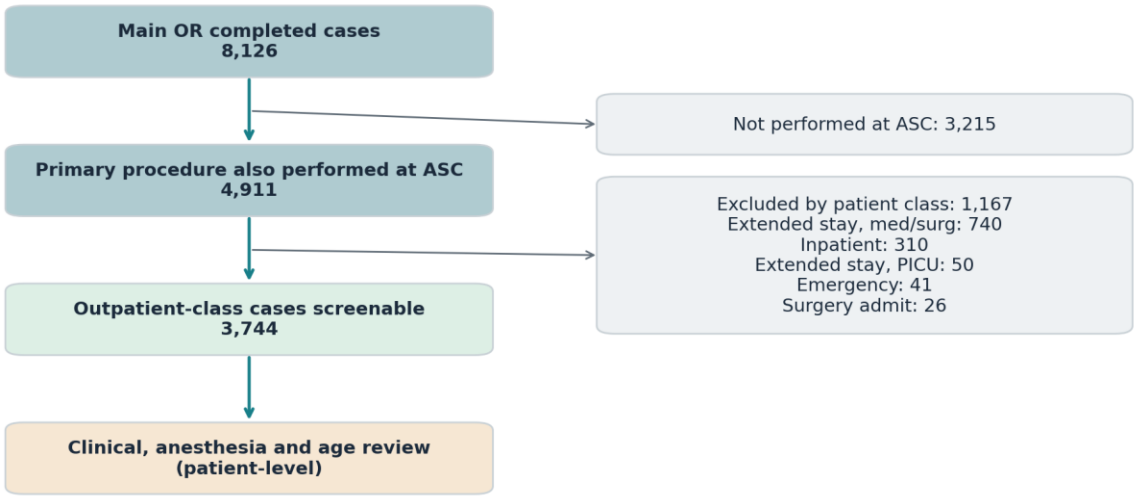


Abstract statement supported: A decision framework that other surgical programs can adapt.

Finding: Each queue falls into one of four positions, and each position calls for a different response: matching, readiness work, service design or capacity.

Basis and source: Conceptual framework from the white paper.

Figure 9. Screening of Main OR cases for ASC suitability



Abstract statement supported: The review revealed a broader allocation opportunity between sites.

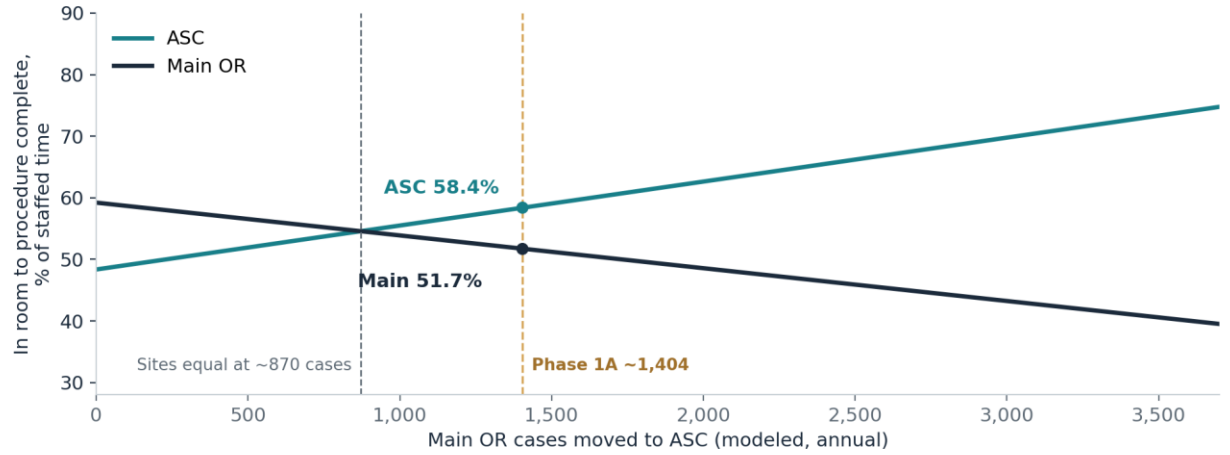
Finding: Of 8,126 Main OR cases, 4,911 had a primary procedure also performed at the ASC, and 3,744 remained after patient-class exclusions.

Basis and source: Volume extract, September 2025–August 2026, matched on primary procedure.

Table 5. Screening results

Measure	White paper [D1]	Volume extract	Status
Main OR cases screened	8,126	8,126	Matches
Primary procedure also performed at ASC	4,640	4,911	Differs
Excluded by patient class	1,004	1,167	Differs
Outpatient-class cases screenable	3,636	3,744	Close match
GI screenable	1,198	1,198	Matches
ENT screenable	Not reported	856	Not reported
Urology screenable	390	392	Matches
Oral surgery screenable	373	375	Matches
GI screenable cases in Main OR Room 6	975	975	Matches
Urology screenable cases in Main OR Room 4	283	284	Matches
Top 10 procedures, share of screenable	68.4%	66.9%	Close match

Figure 10. Modeled effect of moving cases on both sites

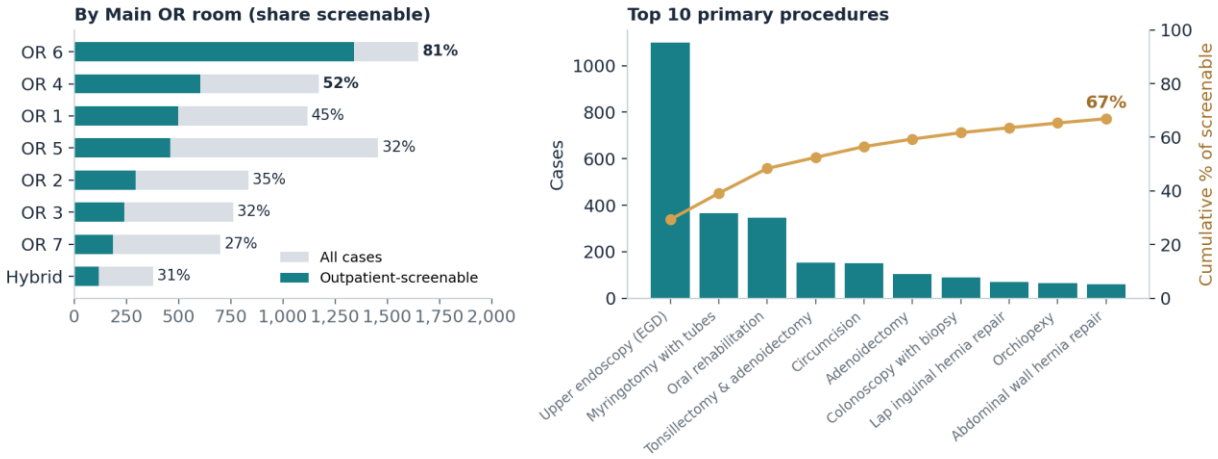


Abstract statement supported: The Main OR and ASC can be managed as complementary enterprise assets; modeled capacity scenarios are not realized outcomes.

Finding: The two sites reach equal utilization at about 870 moved cases. At the Phase 1A level of about 1,404 cases, ASC utilization rises from 48.4% to 58.4% and the Main OR falls from 59.2% to 51.7%, releasing Main OR time for backfill.

Basis and source: Modeled from the Volume extract. Each moved case adds the ASC median time for that procedure (average 0.58 h) and releases its Main OR time (average 0.78 h). In room to procedure complete, as a share of staffed time.

Figure 11. Concentration of screenable cases by room and procedure



Abstract statement supported: The allocation opportunity is specific enough to act on.

Finding: Main OR Room 6 is 81% screenable and Room 4 is 52%. The ten most common primary procedures account for 67% of screenable cases. ENT is the second-largest screenable specialty, with 856 cases.

Basis and source: Volume extract, September 2025–August 2026.

Statements not yet supported by available data

1. **Reported backlog is not the same as ready patients.** The central insight of the paper. Cancellation reasons show readiness problems among scheduled patients, but readiness in the waiting queue is not yet measured. Needed: a patient-level readiness audit.
2. **Effect of overbooking and extended hours.** Needed: start and end dates, hours added, cases generated, overtime used, and a pre-intervention baseline.
3. **Committed utilization (Main OR 83.5%, ASC 68.6%).** Needed: out-of-room times and setup and cleanup minutes for all cases, including add-ons.
4. **Median turnover (ASC 14.8 minutes, Main OR 26.0 minutes).** Needed: out-of-room times to calculate turnover on the white paper's definition.
5. **ASC utilization of about 50% at the time of handover.** Needed: the measurement basis and the period it covers.
6. **Strong patient experience and favorable first-case starts at the ASC.** Needed: patient-experience scores by site. First-case on-time starts can be calculated from the first-case and delay fields in the volume extract.
7. **Physician site choice shaped by convenience.** Needed: surgeon-level site mix for shared procedures, which can be calculated from the volume extract.
8. **Queue readiness over time.** Figure 5 rests on a single snapshot. Needed: weekly snapshots over six to eight weeks.
9. **Time from surgical decision to surgery.** Needed: decision or case-request dates linked to surgery dates.
10. **Conversion of released block time into completed surgery.** Needed: release timing, matched patients, accepted slots and completed cases for the approximately 116 released hours.
11. **Financial scenarios.** Needed: a financial model at the Phase 1A level of about 1,404 cases, reconciled with Finance.
12. **Clinical eligibility of screenable cases.** Needed: patient-level clinical, anesthesia and age review of the 3,744 screenable cases, and documentation of any additional screening filter applied in the white paper.